SERFF Tracking Number:	*UNUM-126340640*	*State:*	*Arkansas*
Filing Company:	*Provident Life and Accident Insurance Company*	*State Tracking Number:*	*44091*
Company Tracking Number:	*AE-1090, ET AL.*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.004 Other*
Product Name:	*Individual Disability Applications*		
Project Name/Number:	*Individual Disability Applications/AE-1090, ET AL.*		

Filing at a Glance

Company: Provident Life and Accident Insurance Company

Product Name: Individual Disability Applications	SERFF Tr Num: UNUM-126340640	State: Arkansas
TOI: H11I Individual Health - Disability Income	SERFF Status: Closed-Approved-Closed	State Tr Num: 44091
Sub-TOI: H11I.004 Other	Co Tr Num: AE-1090, ET AL.	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Lisa Hanson	Disposition Date: 11/17/2009
	Date Submitted: 11/13/2009	Disposition Status: Approved-Closed
Implementation Date Requested: 08/01/2010		Implementation Date:

State Filing Description:

General Information

Project Name: Individual Disability Applications	Status of Filing in Domicile: Pending
Project Number: AE-1090, ET AL.	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 11/17/2009	Explanation for Other Group Market Type:
	State Status Changed: 11/17/2009
Deemer Date:	Created By: Lisa Hanson
Submitted By: Lisa Hanson	Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your review and consideration for approval are the above referenced application forms. These applications are planned for use with our approved individual disability insurance portfolio. These are new forms and are not intended to replace any forms currently on file with your Department. We are concurrently filing these forms in our state of domicile.

Application Form AE-1090 is a short form application designed to be used with our individual disability income policies sold as part of our simplified-issue underwriting programs.

Application Form AE-1091 is also used to apply for our individual disability income policies. The difference between this

application and App AE-1090 is that it will be used for multi-life cases and has additional medical questions.

Enrollment methods include producer-assisted situations (in person or via call centers) and self-enrolled situations (using paper or electronic application processes, such as web-based.) Electronic application processes may also be used in producer-assisted situations.

We reserve the right at any time to make non-material changes to these forms including, but not limited to, paper stock, type face (but not font size) and page layout made necessary by unavoidable changes.

We wish to advise you that concurrent with this application filing, we are also submitting a new individual disability income portfolio, including one policy and multiple riders. It is our intent to use the above applications with this new portfolio, once approved.

Your early consideration and approval of these application forms will be greatly appreciated. Should you have any questions concerning the forms, please contact me at 1-800-451-8475 x76205, by fax at 1-774-437-6005 or by e-mail at LHanson@Unum.com.

Sincerely,

Lisa Hanson
Contract Consultant

Company and Contact

Filing Contact Information

Lisa Hanson, Contract Consultant	lhanson@unum.com	
18 Chestnut Street	774-437-6205 [Phone]	
Worcester, MA 01608	774-437-6005 [FAX]	

Filing Company Information

Provident Life and Accident Insurance Company	CoCode: 68195	State of Domicile: Tennessee
1 Fountain Square	Group Code: 565	Company Type:
Chattanooga, TN 37402	Group Name:	State ID Number:
(800) 451-8475 ext. [Phone]	FEIN Number: 62-0331200	

Filing Fees

SERFF Tracking Number:	*UNUM-126340640*	*State:*	*Arkansas*
Filing Company:	*Provident Life and Accident Insurance Company*	*State Tracking Number:*	*44091*
Company Tracking Number:	*AE-1090, ET AL.*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.004 Other*
Product Name:	*Individual Disability Applications*		
Project Name/Number:	*Individual Disability Applications/AE-1090, ET AL.*		

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Provident Life and Accident Insurance Company	$50.00	11/13/2009	32015476

SERFF Tracking Number:	*UNUM-126340640*	*State:*	*Arkansas*
Filing Company:	*Provident Life and Accident Insurance Company*	*State Tracking Number:*	*44091*
Company Tracking Number:	*AE-1090, ET AL.*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.004 Other*
Product Name:	*Individual Disability Applications*		
Project Name/Number:	*Individual Disability Applications/AE-1090, ET AL.*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/17/2009	11/17/2009

SERFF Tracking Number:	*UNUM-126340640*	*State:*	*Arkansas*
Filing Company:	*Provident Life and Accident Insurance Company*	*State Tracking Number:*	*44091*
Company Tracking Number:	*AE-1090, ET AL.*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.004 Other*
Product Name:	*Individual Disability Applications*		
Project Name/Number:	*Individual Disability Applications/AE-1090, ET AL.*		

Disposition

Disposition Date: 11/17/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UNUM-126340640*	*State:*	*Arkansas*
Filing Company:	*Provident Life and Accident Insurance Company*	*State Tracking Number:*	*44091*
Company Tracking Number:	*AE-1090, ET AL.*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.004 Other*
Product Name:	*Individual Disability Applications*		
Project Name/Number:	*Individual Disability Applications/AE-1090, ET AL.*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	NAIC Transmittal	Approved-Closed	Yes
Supporting Document	AR Certification - Reg 19	Approved-Closed	Yes
Form	Guaranteed Standard Application	Approved-Closed	Yes
Form	Income Protection Application - Multi-life	Approved-Closed	Yes

SERFF Tracking Number:	*UNUM-126340640*	*State:*	*Arkansas*
Filing Company:	*Provident Life and Accident Insurance Company*	*State Tracking Number:*	*44091*
Company Tracking Number:	*AE-1090, ET AL.*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.004 Other*
Product Name:	*Individual Disability Applications*		
Project Name/Number:	*Individual Disability Applications/AE-1090, ET AL.*		

Form Schedule

Lead Form Number: AE-1090

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/17/2009	AE-1090	Application/ Enrollment Form	Guaranteed Standard Application	Initial		51.000	AE-1090.pdf
Approved-Closed 11/17/2009	AE-1091	Application/ Enrollment Form	Income Protection Application - Multi-life	Initial		50.000	AE-1091.pdf

Provident Life and Accident Insurance Company
1 Fountain Square
Chattanooga, Tennessee 37402-1338

GUARANTEED STANDARD APPLICATION

I hereby apply for insurance based on the following representations to Provident Life and Accident Insurance Company (herein referred to as The Company).

SECTION 1: PERSONAL INFORMATION — Always Complete

Proposed Insured: (herein referred to as "You," "Your," "I," "Me" or "My")

1.(a) Name: (Last, First, Middle) Professional Designation | **(b)** Sex: ❑ M ❑ F | **(c)** Date of Birth: (mm/dd/yyyy)

(d) Social Security Number | **(e)** Employee ID Number

(f) Birthplace: (State/Country) | **(g)** Are you a U.S. Citizen ❑ Yes ❑ No **(h)** If "no," what country? _____
(i) If No, do you have a Green Card? ❑ Yes ❑ No
(j) If No, do you have a Visa? ❑ Yes ❑ No What type of Visa _____

(k) Residence Address: Street/Apt No./P.O. Box No. City State Zip **(l)** Res Phone:

(m) Business Address: Street/Apt No./P.O. Box No. City State Zip **(n)** Bus Phone:

(o) Preferred E-mail address at which to be contacted:

2.(a) Employer: | **(b)** Occupation(s) and Title(s):

(c) Annual Earned Income: | **(d)** Date of hire: (mm/dd/yyyy)

3. Number of hours worked per week: _____ hours

4. For the period of time commencing 180 days prior to, and including, the date of this application:	**YES**	**NO**
(a) Have You missed 1 or more days of work, or been homebound or admitted to a medical facility, due to injury or sickness?	❑	❑
(b) Have You had any restrictions or limitations to your ability to work on a full time basis due to injury or sickness?	❑	❑
(c) As of the date this application is signed, are you working on a full time basis without restrictions or limitations due to injury or sickness?	❑	❑

Please provide details including number of days missed, dates and details of restrictions or limitations _____

5. Have You used tobacco in the past 12 months? (*Tobacco means cigarettes, cigars, snuff/dip/chew, pipe or Nicotine Delivery Systems)*	❑	❑
6. Do You need human assistance of any kind to perform everyday activities such as bathing, continence, dressing, eating, using the toilet or transferring (for example, from the chair to Your bed), or do You have any memory loss or confusion?	❑	❑
7. Do You use any medical equipment or appliances such as a cane, wheelchair, catheter, oxygen tank, pacemaker or artificial limb?	❑	❑
8. Do You have any known indication of blindness or deafness, or the loss of use of both arms, both legs, or one arm and/or one leg or any other amputation, or any speech defect?	❑	❑

SECTION 2: EXISTING AND/OR PENDING INSURANCE COVERAGE — Always Complete

1. Do You have any Group Long Term Disability coverage, in force or being applied for? ..... ❑ Yes ❑ No
If yes, what is the monthly benefit amount? _____
Is this coverage Employer pay? ..... ❑ Yes ❑ No

2. Do You have any Individual Disability coverage, in force or being applied for? ..... ❑ Yes ❑ No
(If "Yes", complete the following)

Company Name	Monthly Benefit	Is coverage paid by the employer?	Is insurance being applied for replacing this coverage? ..... If yes, replacement date?	
		❑ Yes ❑ No	❑ Yes ❑ No	
		❑ Yes ❑ No	❑ Yes ❑ No	
		❑ Yes ❑ No	❑ Yes ❑ No	

Please complete and submit state required replacement forms if needed.

SECTION 3: Complete when applying for Serious Illness Benefit

In the past 10 years, have You:

		YES	NO
1.	Been diagnosed with or sought medical treatment (including medication) for heart attack, coronary disease stroke or transient ischemic attack, organ transplant, renal (kidney) disease or failure, hepatitis B or C, cirrhosis, emphysema, chronic obstructive pulmonary disorder or diabetes (excluding gestational diabetes)?	❑	❑
2.	Been prescribed three or more medications to be taken concurrently for high blood pressure?	❑	❑
3.	Been diagnosed with or sought medical treatment (including medication) for: cancer including Leukemia, Hodgkin's Disease, skin cancer (excluding basal cell cancer) or malignant tumors of any kind?	❑	❑

DECLARATION, AGREEMENT AND AUTHORIZATION

I agree with the following statements:

1. The statements and answers in this application are true and complete and correctly recorded. I understand that they will become part of My application and any policies issued on it. If My answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind My coverage.
2. No broker has authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy.
3. The insurance applied for will take effect if one of the following conditions occur:
   a. If the employer is paying the premium, immediately upon the date You fully complete and sign Your application provided You qualify for coverage under the terms and conditions of the offer; or
   b. If You are paying the premium, the first of the month in which premiums are deducted after approval of Your application. (If the application is fully completed and signed after the first of the month in which deductions begin, coverage will be effective on the date of the application.)
   The only exceptions to this are provided in the written agreement between the Company and employer as payor of policy or payroll deduction administrator.
4. I have received a copy of the Notice of Information Practices (including Medical Information Bureau notice and additional information required by the Fair Credit Reporting Act).
5. If coverage applied for qualifies as a benefit under an employee welfare benefit plan established or maintained by the employer and governed by the Employee Retirement Income Security Act of 1974 (ERISA), I acknowledge that my employer delegates the Company, acting through its agents, discretionary authority to make benefit determinations, resolve factual disputes, and interpret provisions of the plan. I will be entitled to appeal any benefit determination made by the Company that I disagree with pursuant to ERISA.
6. I HAVE BEEN INFORMED that any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be prosecuted for insurance fraud.

Disclosure Authorization

I AUTHORIZE: any doctor, hospital, clinic, provider of health care, insurance (or reinsuring) company, Medical Information Bureau Group, Inc., My insurance agents, employers or any other person or firm having: (i) information as to cause, treatment, diagnosis, prognosis or advice of My physical or mental condition; or (ii) any other information needed to determine My eligibility for insurance; to give Unum and its affiliates and its employees and agents or My broker, all such information. This may include (but is not limited to) information about mental illness, and use of alcohol or drugs. I authorize Unum to give MIB Group, Inc. a report of this information. A photocopy of this authorization is valid. I or My authorized representative may request a copy of this authorization. This authorization will be in force for 24 months from the date shown below.

(X) _____ (X) _____

State of Application Dated

(X)_____ (X) _____

Licensed Broker Signature of Proposed Insured

THIS DECLARATION, AGREEMENT AND AUTHORIZATION MUST BE PROPERLY SIGNED, INCLUDING PROPOSED INSURED'S SIGNATURE, BEFORE APPLICATION CAN BE PROCESSED

Provident Life and Accident Insurance Company
1 Fountain Square
Chattanooga, Tennessee 37402-1338

INCOME PROTECTION
APPLICATION - MULTI-LIFE

I hereby apply for insurance based on the following representations to Provident Life and Accident Insurance Company (herein referred to as The Company).

SECTION 1: PERSONAL INFORMATION — Always Complete

Proposed Insured: (herein referred to as "You," "Your," "I," "Me" or "My")

1.(a) Name: (Last, First, Middle) Professional Designation | **(b)** Sex: ❑ M ❑ F | **(c)** Date of Birth: (mm/dd/yyyy)

(d) Social Security Number | **(e)** Employee ID Number

(f) Birthplace: (State/Country) | **(g)** Are you a U.S. Citizen ❑ Yes ❑ No **(h)** If "no," what country? _____
(i) If No, do you have a Green Card? ❑ Yes ❑ No
(j) If No, do you have a Visa? ❑ Yes ❑ No What type of Visa _____

(k) Residence Address: Street/Apt No./P.O. Box No. City State Zip **(l)** Res Phone:

(m) Business Address: Street/Apt No./P.O. Box No. City State Zip **(n)** Bus Phone:

(o) Preferred E-mail address at which to be contacted:

2.(a) Employer: **(b)** Nature of employer's business:

(c) Occupation(s) and title: | **(d)** List or explain Your duties:

(e) Annual Earned Income: | **(f)** Date of hire: (mm/dd/yyyy)

(g) Percent of duties that are: Office _____% Sales _____% Supervisory _____% Manual _____%

3. Number of hours worked per week: _____ hours

4. For the period of time commencing **180 days prior to, and including, the date of this application:**	**YES**	**NO**
(a) Have You missed 1 or more days of work, or been homebound or admitted to a medical facility, due to injury or sickness?	❑	❑
(b) Have You had any restrictions or limitations to your ability to work on a full time basis due to injury or sickness?	❑	❑
(c) As of the date this application is signed, are you working on a full time basis without restrictions or limitations due to injury or sickness?	❑	❑

Please provide details including number of days missed, dates and details of restrictions or limitations _____

5. Have You used tobacco in the past 12 months? (*Tobacco means cigarettes, cigars, snuff/dip/chew, pipe or Nicotine Delivery Systems)*	❑	❑
6. Do You need human assistance of any kind to perform everyday activities such as bathing, continence, dressing, eating, using the toilet or transferring (for example, from the chair to Your bed), or do You have any memory loss or confusion?	❑	❑
7. Do You use any medical equipment or appliances such as a cane, wheelchair, catheter, oxygen tank, pacemaker or artificial limb?	❑	❑
8. Do You have any known indication of blindness or deafness, or the loss of use of both arms, both legs, or one arm and/or one leg or any other amputation, or any speech defect?	❑	❑

SECTION 2: EXISTING AND/OR PENDING INSURANCE COVERAGE — Always Complete

	YES	**NO**
1. Do You have any Group Long Term Disability coverage, in force or being applied for?	❑	❑
If yes, what is the monthly benefit amount? _____		
Is this coverage Employer pay?	❑	❑
2. Do You have any Individual Disability coverage, in force or being applied for?	❑	❑

(If "Yes", complete the following)

Company Name	Monthly Benefit	Is coverage paid by the employer?	Is insurance being applied for replacing this coverage?	If yes, replacement date?
		❑ Yes ❑ No	❑ Yes ❑ No	
		❑ Yes ❑ No	❑ Yes ❑ No	
		❑ Yes ❑ No	❑ Yes ❑ No	

Please complete and submit state required replacement forms if needed.

SECTION 2: EXISTING AND/OR PENDING INSURANCE COVERAGE — Always Complete (continued)

	YES	NO
3. (a) Will any premium for coverage being applied for be paid by employer? If Yes, what percentage? _____%	❑	❑
(b) Will employer's contribution be included in Your taxable income?	❑	❑

SECTION 3: Complete when applying for Serious Illness Benefit

In the past 10 years, have You:

	YES	NO
1. Been diagnosed with or sought medical treatment (including medication) for heart attack, coronary disease stroke or transient ischemic attack, organ transplant, renal (kidney) disease or failure, hepatitis B or C, cirrhosis, emphysema, chronic obstructive pulmonary disorder or diabetes (excluding gestational diabetes)?	❑	❑
2. Been prescribed three or more medications to be taken concurrently for high blood pressure?	❑	❑
3. Been diagnosed with or sought medical treatment (including medication) for: cancer including Leukemia, Hodgkin's Disease, skin cancer (excluding basal cell cancer) or malignant tumors of any kind?	❑	❑

SECTION 4: FINANCIAL INFORMATION — Complete when applying for fully underwritten coverage

	ACTUAL CURRENT	ACTUAL LAST YEAR	ACTUAL 2 YEARS AGO
1. What is your annual Earned Income:	$	$	$

2. Are You a(n): ❑ Non-owner employee ❑ Owner (If owner, please check appropriate entity below.)
❑ Sole Proprietor ❑ Partnership ❑ Limited Liability Company ❑ C-Corp ❑ S-Corp

3. If an owner of Your own business or practice, what is Your:
(a) Percentage of ownership? _____% **(b)** Length of ownership? _____ years
(c) Number of full time employees _____

SECTION 5: MEDICAL INFORMATION — Complete when applying for fully underwritten coverage

	YES	NO
1. (a) Have You ever been diagnosed or treated by a member of the medical profession for or been informed that You have Acquired Immune Deficiency Syndrome (AIDS)?	❑	❑
(b) Have You ever tested positive for antibodies to Human Immunodeficiency Virus (HIV)?	❑	❑
2. Have You ever:		
(a) Sought, been advised to seek or received counseling or treatment for the use of alcohol?	❑	❑
(b) Used narcotics, cocaine, heroin, hallucinogens, barbiturates, marijuana, or other habit forming drugs; sought, or been advised to seek or received counseling or treatment for or ever been arrested for the possession of or use of prescribed or non-prescribed drugs?	❑	❑
3. Other than above, have You, within the past 10 years, had medical or surgical advise or treatment, had a physical examination or been under observation or treatment, or do You have a physical impairment or deformity?	❑	❑
4. Are you presently under treatment for any disease or disorder?	❑	❑

Please list below all medications you are presently taking

_____

_____

5. Have You ever been advised to have or received treatment or counseling for an attention deficit disorder, mental, emotional, nervous, anxiety, behavioral or eating disorder, stress, depression or marital counseling?	❑	❑

6. (a) What is Your: Height: _____ (feet) _____ (inches) **(b)** Weight: _____ (pounds)

7. (a) Please provide the name and address of Your personal physician(s). If none, write "none".

_____

(b) Please provide dates last seen and reason for consultation. _____

8. (a) Please provide the name and address of any other physicians you have seen. If none, write "none".

_____

(b) Please provide dates last seen and reason for consultation. _____

MEDICAL DETAILS

Please provide details for each condition to which You answered "yes" to the questions above.

Question #	

SECTION 6: DECLARATION, AGREEMENT AND AUTHORIZATION

I agree with the following statements:

1. The statements and answers in this application are true and complete and correctly recorded. I understand that they will become part of My application and any policies issued on it. If My answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind My coverage.
2. I will permanently discontinue any group or individual policy(ies) shown to be discontinued in answer to question 2 in Section 4 on or before the date(s) indicated. The Company will rely on such answers in determining the amount of, if any, insurance it will issue. Benefits under any policy issued on this application may be reduced by the amount payable under such existing policies.
3. No broker has authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy.
4. The Company has the right to require medical exams and tests to determine insurability.
5. The insurance applied for will not take effect unless the issuance and delivery of the policy and payment of the first premium occur while My health and any other person to be insured under the policy remains as stated in the Application. The only exception to this is provided in the Conditional Receipt detached here from and issued if one sixth of the annual premium is paid in advance.
6. The Company is authorized to obtain an investigative consumer report on Me.
7. Acceptance by the Proposed Insured/Owner of any policy issued on this Application will ratify any changes made by amendments.
8. I have received a copy of the Notice of Information Practices (including Medical Information Bureau notice and additional information required by the Fair Credit Reporting Act).
9. If coverage applied for qualifies as a benefit under an employee welfare benefit plan established or maintained by the employer and governed by the Employee Retirement Income Security Act of 1974 (ERISA), I acknowledge that my employer delegates the Company, acting through its agents, discretionary authority to make benefit determinations, resolve factual disputes, and interpret provisions of the plan. I will be entitled to appeal any benefit determination made by the Company that I disagree with pursuant to ERISA.
10. I HAVE BEEN INFORMED that any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be prosecuted for insurance fraud.

Disclosure Authorization

I AUTHORIZE: any doctor, hospital, clinic, provider of health care, insurance (or reinsuring) company, consumer reporting agency, Medical Information Bureau Group, Inc., My insurance agents, employers or any other person or firm having: (i) Information as to cause, treatment, diagnosis, prognosis or advice of my physical or mental condition; or (ii) any other information needed to determine My eligibility for insurance; to give Unum and its affiliates and its employees and agents, My broker, or any consumer reporting agency, all such information. This may include (but is not limited to); information about driving records, mental illness, and use of alcohol or drugs.

I understand the information obtained with this authorization will be used by the Company to determine my eligibility for insurance. A photocopy of this authorization is valid. I or My authorized representative may request a copy of this authorization. This authorization will be in force for 24 months from the date shown below.

_____ Signed at: City and State

_____ Dated

I certify that I have truly and accurately recorded on this Application the information that was supplied by the proposed insured.

(X) _____ Signature of Proposed Insured

(X)_____ Witness: Licensed Broker

(X) _____ Signature of Proposed Owner

THIS DECLARATION, AGREEMENT AND AUTHORIZATION MUST BE PROPERLY SIGNED, INCLUDING PROPOSED INSURED'S SIGNATURE, BEFORE APPLICATION CAN BE PROCESSED

SERFF Tracking Number:	*UNUM-126340640*	*State:*	*Arkansas*
Filing Company:	*Provident Life and Accident Insurance Company*	*State Tracking Number:*	*44091*
Company Tracking Number:	*AE-1090, ET AL.*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.004 Other*
Product Name:	*Individual Disability Applications*		
Project Name/Number:	*Individual Disability Applications/AE-1090, ET AL.*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/17/2009
Comments:			
Attachment:			

Readability Certification (0071a).pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/17/2009
Bypass Reason:	This is an application filing. The applications to be approved are attached to the Form Schedule.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	11/17/2009
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	11/17/2009
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	11/17/2009
Comments:			
Attachment:			

AR Filing Letter.pdf

SERFF Tracking Number:	*UNUM-126340640*	*State:*	*Arkansas*
Filing Company:	*Provident Life and Accident Insurance Company*	*State Tracking Number:*	*44091*
Company Tracking Number:	*AE-1090, ET AL.*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.004 Other*
Product Name:	*Individual Disability Applications*		
Project Name/Number:	*Individual Disability Applications/AE-1090, ET AL.*		

		Item Status:	**Status Date:**
Satisfied - Item:	NAIC Transmittal	Approved-Closed	11/17/2009

Comments:

Attachment:

NAIC Transmittal (rev 1-1-09).pdf

		Item Status:	**Status Date:**
Satisfied - Item:	AR Certification - Reg 19	Approved-Closed	11/17/2009

Comments:

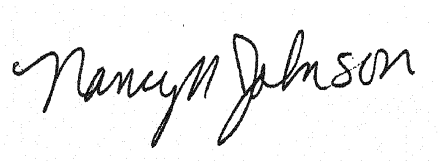
Attachment:

Regulation 19 - PLA.pdf

CERTIFICATE OF READABILITY

This is to certify that the forms listed below have achieved the Flesch Reading Ease Scores shown and that they comply with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form No.	Title	Flesch Score
AE-1090	Guaranteed Standard Application	51
AE-1091	Income Protection Application – Multi-Life	50



Prepared by: _____

Name: Nancy Johnson
Title: Vice President, Contract Compliance & Filings

18 Chestnut Street
Worcester, MA
01608-1528
508 799 4441
www.unum.com

November 13, 2009

Arkansas Department of Insurance
Compliance and Health Section
1200 West Third Street
Little Rock, AR 72201

Re: **Provident Life and Accident Insurance Company**
NAIC: 565-68195 FEIN: 62-0331200
Individual Disability Applications
Form AE-1090, Guaranteed Standard Application
Form AE-1091, Income Protection Application – Multi-Life

Enclosed for your review and consideration for approval are the above referenced application forms. These applications are planned for use with our approved individual disability insurance portfolio. These are new forms and are not intended to replace any forms currently on file with your Department. We are concurrently filing these forms in our state of domicile.

Application Form AE-1090 is a short form application designed to be used with our individual disability income policies sold as part of our simplified-issue underwriting programs.

Application Form AE-1091 is also used to apply for our individual disability income policies. The difference between this application and App AE-1090 is that it will be used for multi-life cases and has additional medical questions.

Enrollment methods include producer-assisted situations (in person or via call centers) and self-enrolled situations (using paper or electronic application processes, such as web-based.) Electronic application processes may also be used in producer-assisted situations.

We reserve the right at any time to make non-material changes to these forms including, but not limited to, paper stock, type face (but not font size) and page layout made necessary by unavoidable changes.

We wish to advise you that concurrent with this application filing, we are also submitting a new individual disability income portfolio, including one policy and multiple riders. It is our intent to use the above applications with this new portfolio, once approved.

Your early consideration and approval of these application forms will be greatly appreciated. Should you have any questions concerning the forms, please contact me at 1-800-451-8475 x76205, by fax at 1-774-437-6005 or by e-mail at LHanson@Unum.com.

Sincerely,

Lisa Hanson

Lisa Hanson
Contract Consultant

Effective January 1, 2009

Reset Form

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas

2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Provident Life and Accident Insurance Company 1 Fountain Square Chattanooga, TN 37402	TN		565	68195	62-0331200	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Lisa Hanson Unum 18 Chestnut Street Worcester, MA 01608	800-451-8475 x76205	774-437-6005	LHanson@Unum.com

5.	Requested Filing Mode	☑ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	Company Tracking Number	AE-1090, et al.
7.	☑ New Submission ☐ Resubmission	Previous file # _____
8.	Market	☑ Individual ☐ Franchise Group: ☐ Small ☐ Large ☐ Small and Large ☐ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	Type of Insurance	**H11I Individual Health-Disability Income**
10.	Product Coding Matrix Filing Code	**H11I.004 Other**
11.	Submitted Documents	☐ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☑ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other **Rates** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreements ☐ Statement of Variability ☐ Certifications ☐ Actuarial Memorandum ☐ Other_____

12.	**Filing Submission Date**	11/13/2009
13	**Filing Fee (If required)**	Amount $50 Check Date Retaliatory ☐ Yes ☑ No Check Number
14.	**Date of Domiciliary Approval**	Filing concurrently
15.	**Filing Description:**	

View Complete Filing Description

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Lisa Hanson Title Contract Consultant

Signature Lisa M. Hanson Digitally signed by Lisa M. Hanson DN: cn=Lisa M. Hanson, c=US, o=Unum Law Dept, ou=Contract Compliance and Filings, email=LHanson@Unum.com Reason: I am the author of this document Date: 2009.11.13 11:05:17 -05'00' Date: November 13, 2009

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	
This filing corresponds to rate filing company tracking number	

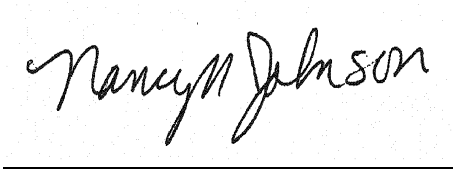
	Document Name / Description	Form Number		Replaced Form Number / Previous State Filing Number
01	Guaranteed Standard Application	AE-1090	☑ Initial ☐ Revised ☐ Other _____	
02	Income Protection Application - Multi-life	AE-1091	☑ Initial ☐ Revised ☐ Other _____	
03			☐ Initial ☐ Revised ☐ Other _____	
04			☐ Initial ☐ Revised ☐ Other _____	
05			☐ Initial ☐ Revised ☐ Other _____	
06			☐ Initial ☐ Revised ☐ Other _____	
07			☐ Initial ☐ Revised ☐ Other _____	
08			☐ Initial ☐ Revised ☐ Other _____	
09			☐ Initial ☐ Revised ☐ Other _____	
10			☐ Initial ☐ Revised ☐ Other _____	

18.	Rate Filing Attachment			
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing			**%**	
	Document Name **Description**	**Affected Form Numbers**		**Previous State Filing Number**
01			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
02			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
03			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
04			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
05			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
06			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
07			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
08			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
09			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
10			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	

LH RFA-1

CERTIFICATION REQUIRED BY
ARKANSAS INSURANCE DEPARTMENT REGULATION 19

I certify that this submission meets the provisions of Regulation 19 as well as all other applicable requirements of the Arkansas Insurance Department.



Signature

Nancy Johnson
Vice President

Date: November 12, 2009

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
CHATTANOOGA, TENNESSEE